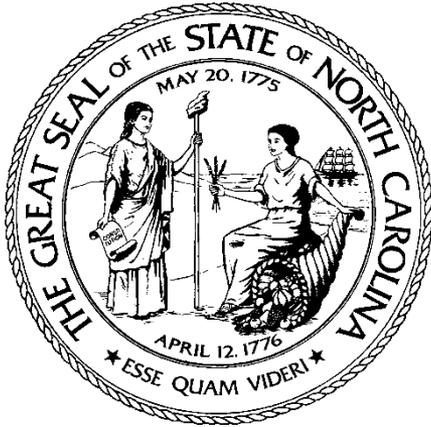


BH I/DD Tailored Care Management

If you experience technical difficulties during the WebEx session,
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- Please note that this webinar is being recorded
- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
 - You may ask an online question at any time throughout the presentation, using the Q&A text box
 - Q&A Text Box is located on the *lower right hand* side of the screen
 - Simply type in your question and click send
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- Live closed captioning is available

For more information on Medicaid Transformation, please visit:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>



BH I/DD Tailored Care Management

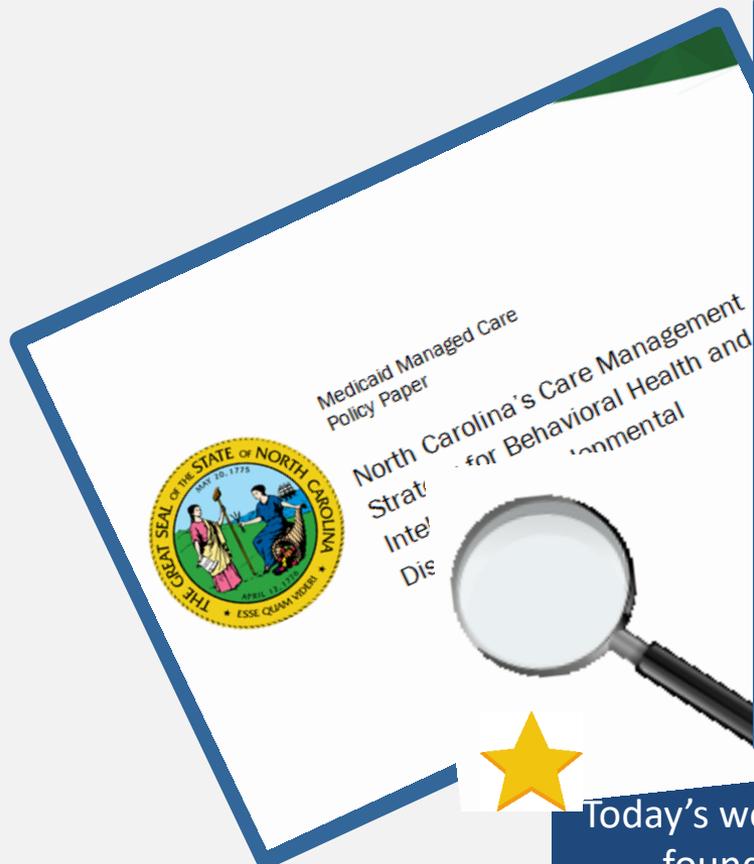
May 30, 2019

Agenda

- **Background and Guiding Principles**
- **Tailored Care Management Model**
- **Key Takeaways**

BH I/DD Tailored Care Management Paper

On May 29, 2019, North Carolina’s Department of Health and Human Services (the Department) released “North Carolina’s Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans.”



The paper provides an overview of the BH I/DD Tailored Care Management design developed to date, including:

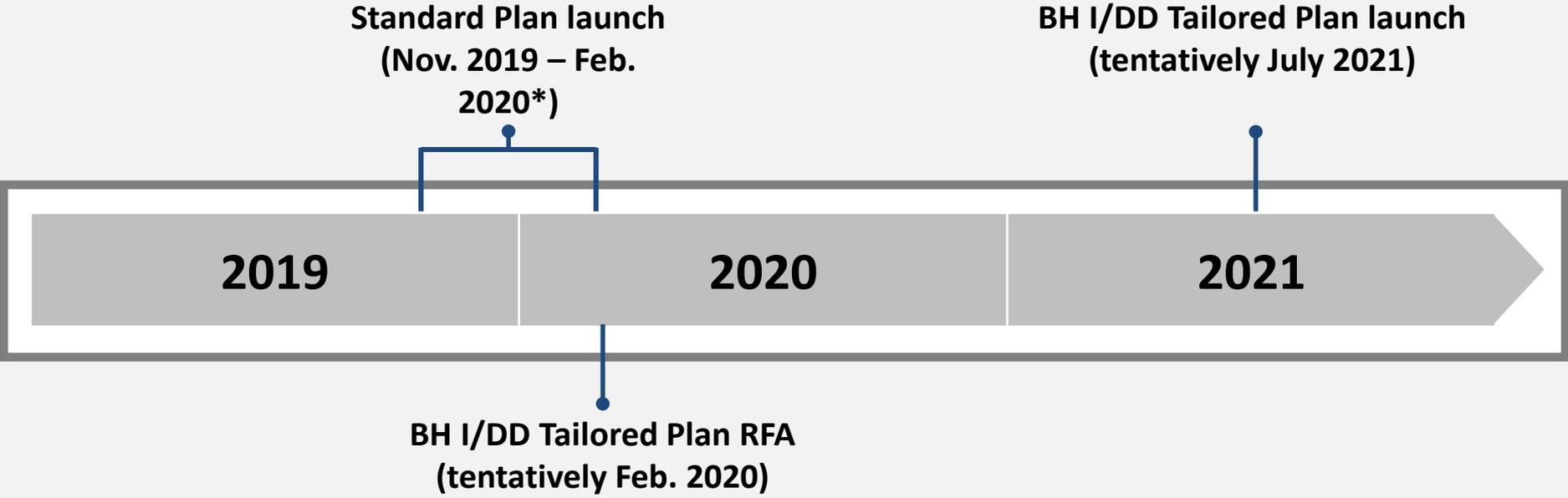
- Guiding principles
- Transition to whole-person care management
- Federal Health Home structure
- Provider-based care management
- Care management process flow
- Care manager qualifications and training
- Conflict-free care management
- Payment for care management

Today’s webinar reviews key concepts in the paper. The full paper can be found on the Department’s Medicaid Transformation webpage.

Background and Guiding Principles

Timeline for Managed Care Transition

North Carolina is in the midst of large scale Medicaid transformation efforts, with two types of managed care products—Standard Plans and BH I/DD Tailored Plans—launching in the next two years.



*Standard Plan launch date will vary by region and will be in either Nov. 2019 or Feb. 2020.

Standard Plans and BH I/DD Tailored Plans

Both Standard Plans and BH I/DD Tailored Plans will be integrated managed care products and will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits.

Standard Plans

- Will serve the majority of the non-dual eligible Medicaid population

BH I/DD Tailored Plans

- Targeted toward populations with:
 - significant behavioral health conditions—including serious mental illness, serious emotional disturbance, and severe substance use disorders
 - intellectual and developmental disabilities (I/DD), and
 - traumatic brain injury (TBI)
- Will offer a more robust set of behavioral health and I/DD benefits than Standard Plans and will be the only plans to offer current 1915(b)(3), 1915(c) Innovations and TBI waiver, and State-funded services

BH I/DD Tailored Care Management

The care management model in BH I/DD Tailored Plans will be known as
“Tailored Care Management.”

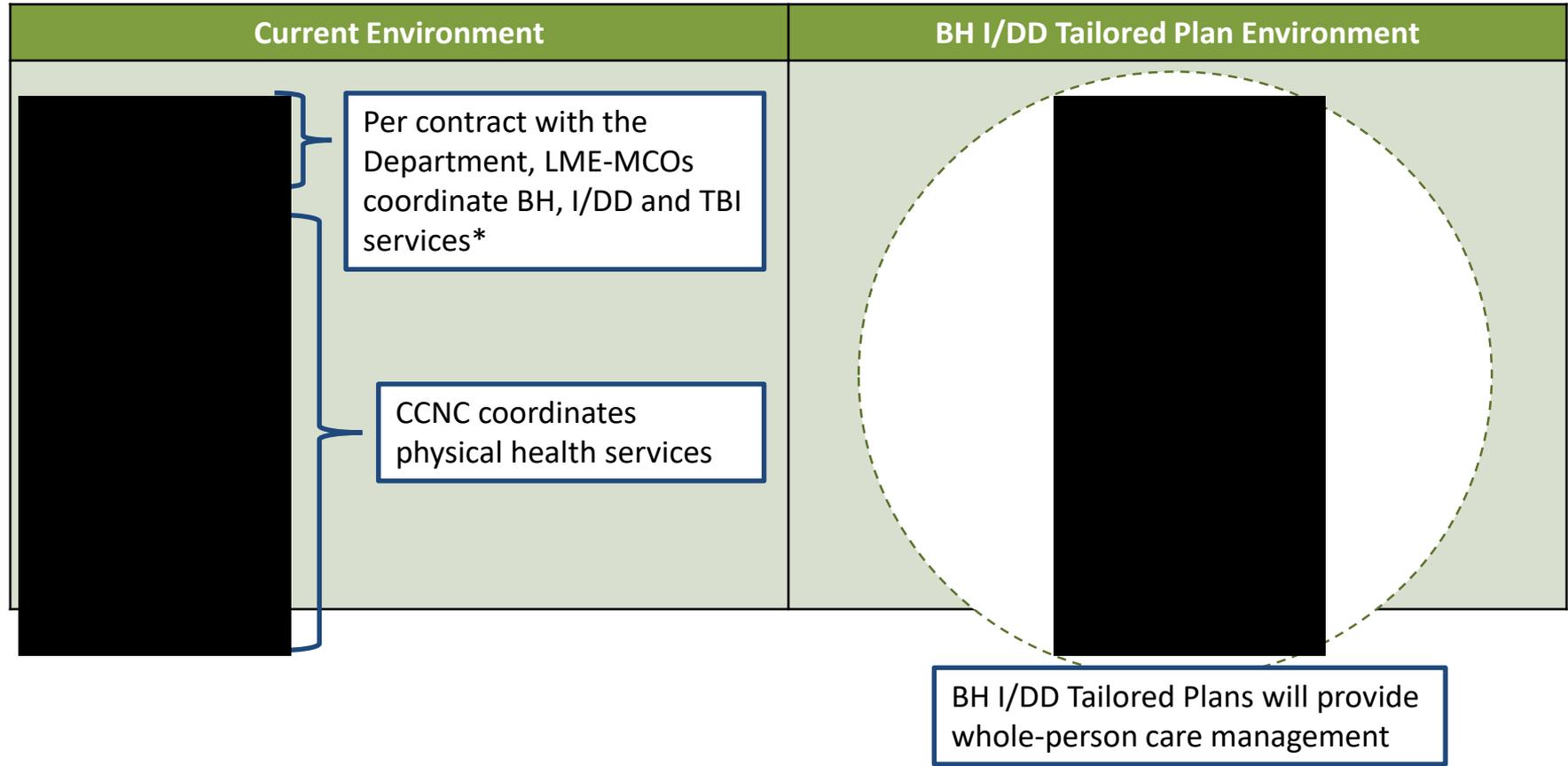
Core Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources



Transition to Whole-Person Care Management

The Tailored Care Management model reflects the Department's broader goal for integrated, whole-person care in the Medicaid managed care environment.



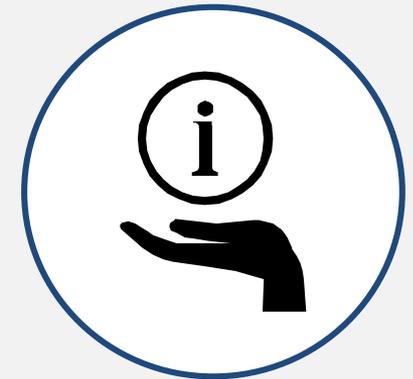
*LME-MCOs do not provide care coordination for populations excluded from LME-MCOs, such as children under age 3 and children enrolled in NC Health Choice.

Tailored Care Management Model

Rationale for Tailored Care Management Model

The Tailored Care Management model is a pathway to ensuring BH I/DD Tailored Plan beneficiaries have access to the best whole-person care possible.

- All BH I/DD Tailored Plan beneficiaries need integrated, whole-person care management.
- **Provider-based care management** promotes **integrated care** and offers beneficiaries **choice** in how they receive care management.*
- **Community-based care management** facilitates frequent **face-to-face** interaction between beneficiaries and their care managers, who will live and work in the same communities as the individuals they serve.
- All BH I/DD Tailored Plan beneficiaries should have access to **consistent, high-quality care management** regardless of **geography** or where their care manager is employed.



*Beneficiaries will be able to switch care managers at any time.

Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

**BH I/DD Tailored Plan
Health Home**

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
“AMH+” Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
**BH I/DD Tailored Plan-
Employed Care Manager**

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Glide Path to Provider-based Care Management

Tailored Care Management will require a multiyear effort to enhance the workforce at the AMH+ and CMA level. The Department will establish a “glide path” to guide the growth of provider-based capacity.

$$\begin{array}{l}
 \text{Numerator:} \\
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 \frac{\text{Number of enrollees actively engaged in care management and served by care managers based in CMAs/AMH+ practices}}{\text{Total number of beneficiaries actively engaged in care management}} \times 100 = X\%$$

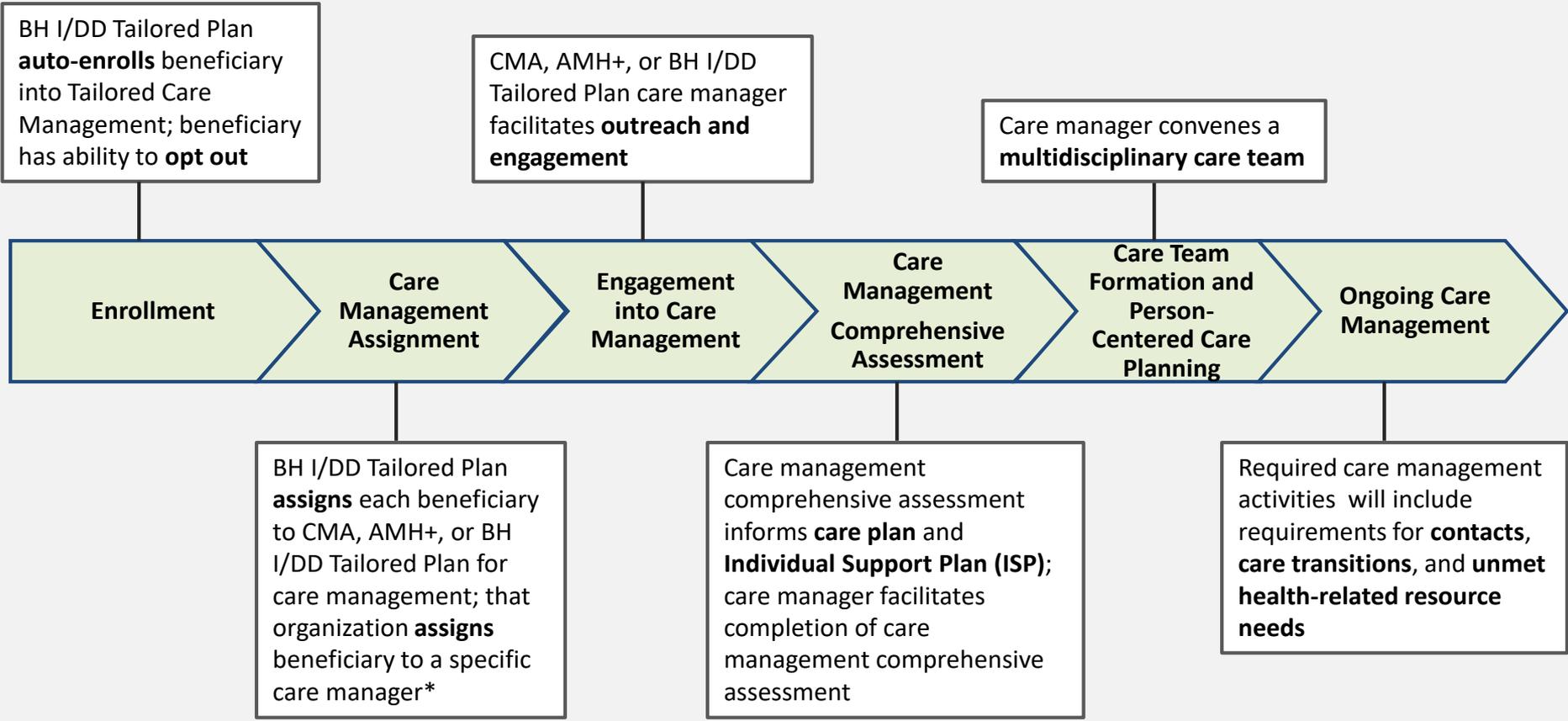
Department will compare X to annual targets:

	Year 0 (May 2020)	Year 1 (Mid 2021)	Year 2 (Mid 2022)	Year 3 (Mid 2023)	Year 4 (Mid 2024)
Target percentage of beneficiaries served by care managers/supervisors based in CMA/AMH+	N/A	Target 1	Target 2	Target 3	Target 4 = 80%

The Department believes that provider- and community-based care management is critical to the success of fully integrated managed care.

Care Management Process Flow

Care management design aligns with Standard Plan requirements to the greatest extent possible, but in several areas the Department is building special guardrails to meet the unique needs of the BH I/DD Tailored Plan population.



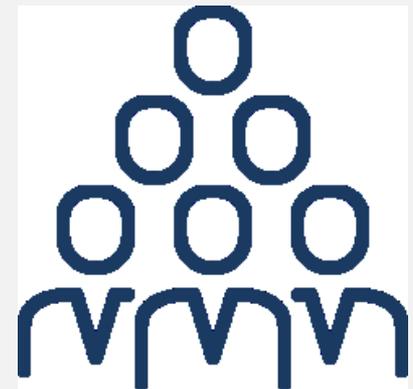
*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve BH I/DD Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Acuity Tiering and Contact Requirements

The Department plans to establish a standardized methodology for determining acuity of each beneficiary based on claims history.

Acuity Tiers

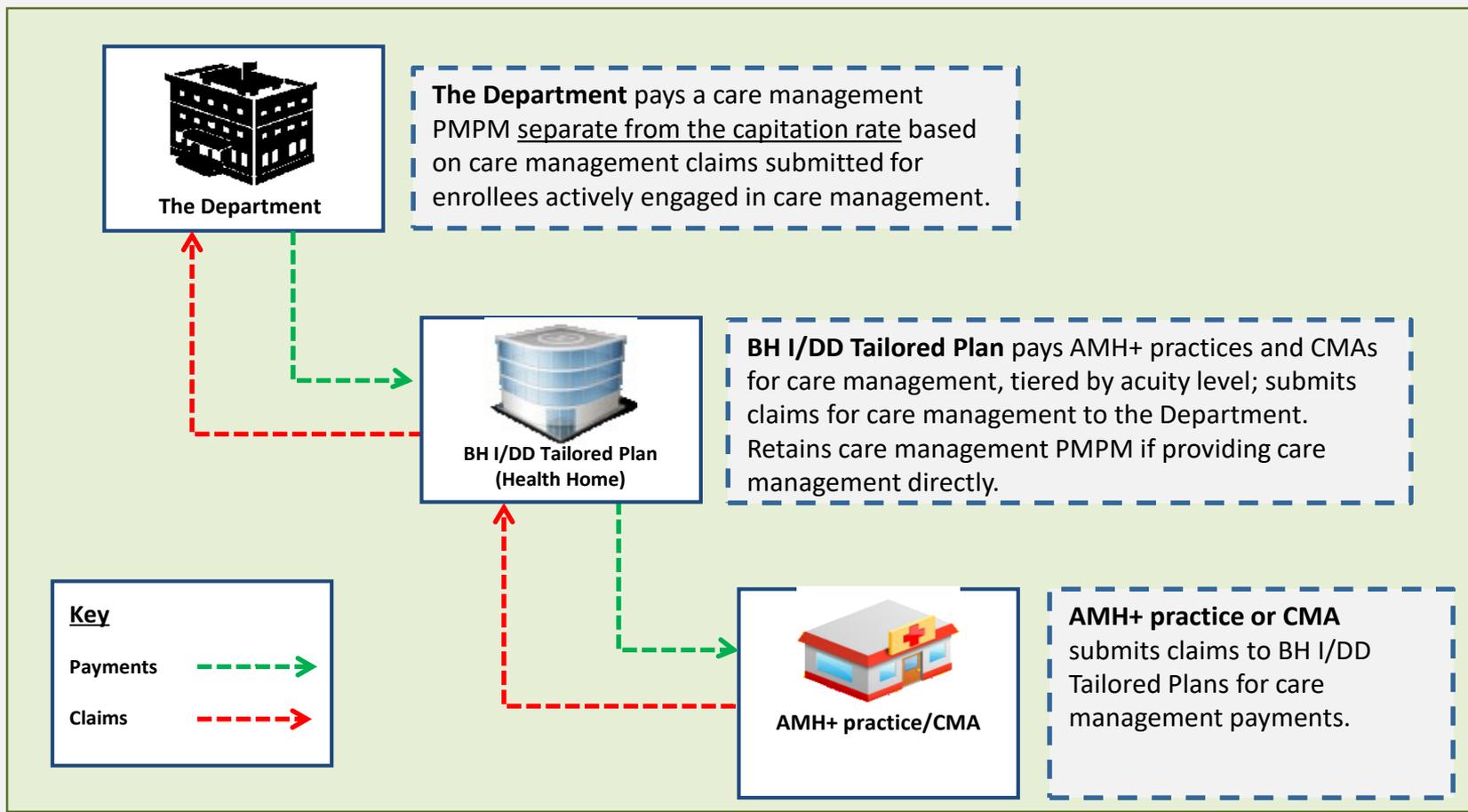
- Beneficiaries will be placed into high, moderate, or low acuity tiers
- Acuity tiers will be used to guide payment levels
- Acuity tiers will also be used to guide minimum required levels of contact between care managers and beneficiaries
 - *As market experience with the model grows, the Department may transition away from these contact requirements to increase the focus on outcomes, to the extent allowed by federal Health Home requirements*



In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will also require that care managers and supervisors serving this population possess a **minimum set of qualifications**. (see paper for details)

Payment for Care Management

Tailored Care Management payments will be subject to set minimum rates that are tiered by beneficiary acuity and, generally, *significantly higher* than Standard Plan care management rates.



Quality

BH I/DD Tailored Plans will be required to report measures that assess whole-person outcomes.

Federal Health Home Quality Measures

- Adult Body Mass Index (BMI) Assessment
- Prevention Quality Indicator (PQI) 92: Chronic Condition Composite
- Care Transition – Transition Record Transmitted to Health Care Professional
- Follow-Up After Hospitalization for Mental Illness
- Plan All-Cause Readmission Rate
- Screening for Clinical Depression and Follow-Up Plan
- Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment
- Controlling High Blood Pressure

Measures additional to the above federally-required set will be forthcoming.

Data and Health Information Technology

The Department will establish minimum requirements for HIT and data sharing.

IT Capabilities Supporting Care Management

- Manage population health
- Respond to individual beneficiary needs
- Track referrals and follow-ups
- Monitor medication adherence
- Respond to unmet health-related resource needs
- Document and store beneficiary care plans/ISPs
- Facilitate “warm hand-offs” of beneficiaries between plans, care managers, and care settings, as needed
- Interface with NCCARE360



The Department will work with BH I/DD Tailored Plans, AMH+ practices, and CMAs after contracts are awarded to develop consensus around specific data formats, contents, triggers, and transmission methods for critical data exchanges.

Key Takeaways

Key Takeaways

- Tailored Care Management will **build upon the Standard Plan care management model**, but will be significantly more intensive and customized, reflecting the needs of the population.
- **Tailored Care Management will be available throughout the entire duration of a beneficiary's enrollment in a BH I/DD Tailored Plan** (with limited exceptions); will prioritize frequent in-person interactions between care managers and beneficiaries; and will place strong emphasis on outcomes.
- The care management design is built on the core principle that provider- and community-based care management is critical to the success of fully integrated managed care.
 - Recognizing that the expansion of the population eligible for care management services will require a multiyear effort to enhance the workforce at the AMH+ and CMA level, the Department will establish a **glide path** for the provision of provider-based care management.
- In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will require minimum **contact requirements** and require that care managers serving this population possess a set of **minimum qualifications**.

Reminder: Opportunities to Engage

The Department values input and feedback from stakeholders and will make sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website:
<https://www.ncdhhs.gov/assistance/medicaid-transformation>



Groups The Department Will Engage

- Consumers, Families, Caregivers, and Consumer Representatives
- Providers
- Health Plans and LME-MCOs
- Counties
- General Public

Comments? Questions? Let's hear from you!

Comments, questions, and feedback are all very welcome at
Medicaid.Transformation@dhhs.nc.gov